STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		IDENTIFICATION NUMBER:	A. BUILDING B. WING CCC 03			(X3) DATE S COMPL 03/15/	ETED
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE 53RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE			IN 46410		
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
W000000						•	
	This visit was for the investigation of complaint #IN00123154.		W0	00000			
		0123154: ΓED, Federal and State ed to the allegation was					
	Unrelated defici	encies cited.					
	1	February 27, 28, March , 13, 14, and 15, 2013.					
	Facility number Provider numbe AIM number: 10	r: 15G040					
	III/QMRP-Tean	Medical Surveyor n Leader , Medical Surveyor					
	state findings in 9.	eficiencies also reflect accordance with 460 IAC impleted 3/25/13 by Ruth cal Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/15/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000102	GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (A, B, and C) and for 2 additional clients (clients D and E). The governing body failed to provide oversight and management of Nursing Services. The governing body failed to ensure the facility put in place a plan to provide Nursing Services with oversight by a Registered Nurse. Findings include: Please refer to W104. The governing body failed to provide oversight of the facility's nursing services to meet the needs of clients A and B in regard to monitoring each client's health care needs, assessing client A's skin breakdown, developing a risk plan specific to meet the identified health care needs of clients A and B, failed to ensure client A's blood pressure readings were recorded, to complete client A's skin assessments/body checks, and to document client A's repositioning. The facility's nursing services failed to ensure staff were trained to provide care/treatment of client A and B's healthcare needs for 2 of 3 sampled	W000102	An RN was contracted on 1/20 to conduct medication administration classes and wa available for at time of Nursing Manager's absence if needed The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, took phone calls in the hospita just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to a staff and worked directly with contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, and RN was hired as Director of Health Services. One LPN position remains open with a temporary nurse filling in until suitable replacement can be found. So at the present time The Arc Northwest Indiana employs two RNs, two LPNs, one temp LPN. All other hom were affected by this dramatic change in nursing staff. Thes new nurses will serve 53 th ar our other group homes. In addition an experienced RN we stay on staff until such time the these new nurses are up to specific process.	she all she can a a she can a she

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MUL ² A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 03/15/2	ETED	
	clients (clients A Please refer to W body failed to me Participation: He facility failed to monitoring and c services for 3 of A, B, and C) and (clients D and E) failed to exercise operating directive ensure the facility each client's ider in regard to failinhealth care needs assessments, and specific for: skin repositioning, re- readings, develop assessments, imp facility's policy a medication secur labeling. The go exercise general direction over th Licensed Nursin health needs from available to cons licensed practica	ANA INC, THE TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) and B). 7318. The governing eet the Condition of ealth Care Services, as the provide health care oversight of nursing 3 sampled clients (clients two additional clients the governing body to general policy and to over the facility to ty's nursing services met entified health care needs the governing body to monitor the clients' to, complete documented to provide staff training breakdown, cording blood pressure to pressure to pressure to provide the staff training to breakdown, to cording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to provide the staff training to breakdown, to ording blood pressure to ordinate the staff training blood pressure to ordinate the staff training blood pressure to ordinat	PR	300 W 5	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) temporary nursing agency so there is no delay in replacing a nurse should one not be able to fulfill their job duties. In the absence of the Director of Heat Services, the Director of Community Services was responsible for assuring policie and procedures and nursing services. The Director of Heat Services is taking on this responsibility and is responsible for future monitoring of nursing services. When a consumer is hospitalized the Community Services Nurse in coordination with the Service Coordinator with the Service Coordinator with the Service Coordinator will be held within 24 hours pri to or following discharge with the day program and others relevate to the client's care and documente am discussion and approvale necessary. To prevent reoccurrence, this will be done all consumers returning home after hospitalization as a standard practice. The Behavior Health Director or the Community Services Operations Director whold a weekly meeting to revie changes in client status and ensure these meetings are scheduled or have been completed and document this discussion.	that that that that that that that that	(X5) COMPLETION DATE

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CC A. BUILDING B. WING	00	_			
	PROVIDER OR SUPPLIE	DIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	9-3-1(a)							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		A. BUILDING 00			COMPL 03/15/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE		
	NORTHWEST INDI				IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000104	483.410(a)(1) GOVERNING BO	nv					
		dy must exercise general					
		d operating direction over					
	the facility.						
	Based on observa	ation, interview, and	W0	00104	Please see W 102 in addition		04/14/2013
	record review, th	e facility's governing			The wound care tracking shee	t	
	body failed to ex	ercise operating direction			and work instructions were		
	over the facility f	for 3 of 3 sampled clients			revised again on 4/14/13. The community service nurse will		
	(clients A, B, and	d C) and two additional			identify when this procedure is		
	clients (clients D	and E), to provide			required the work instruction		
	oversight of the f	facility's nursing services			identifies times when clients an	е	
	•	s of clients A and B in			at greater risk. When needed Staff will complete the wound		
	regard to monitor	ring each client's health			tracking sheet and will fax it in	to	
	•	sing client A's skin			the Nurse daily for review with		
		loping a risk plan			hard copy being sent into the		
		the identified health care			office weekly. In addition othe		
	-	A and B, failed to ensure			consumers with health risks su as blood pressures, completing		
		pressure readings were			body checks, use of a Hoyer li	-	
	•	plete client A's skin			repositioning, and wound care		
	assessments/body	_			have their risk plans evaluated	or	
		A's repositioning. The			developed and all staff will be trained on them by 4/14/13. To		
		ng body failed to exercise			ensure adherence to these ne		
		on over the facility's			risk plans the service coordina		
		to ensure staff were			in conjunction with the commu	nity	
					services nurse will visit the hor		
	A and B's health	e care/treatment of client			on a bi weekly basis to ensure		
					staff are implementing the plar appropriately.	13	
		ity for clients A, B, C, D,					
	and E.						
	Findings include	:					
	S						
	The governing bo	ody failed to exercise					
		d operating direction					
		to ensure the facility's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G040	B. WING			03/15/	2013
			D. 17210		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			53RD AVE		
ARC OF	NORTHWEST IND	DIANA INC, THE			IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	nursing services	s met client A's health care					
	needs in regard	to monitoring the client					
	A's health need	s, assessing client A's skin					
		veloping a risk plan					
		t the health care need of					
	-	ng the facility staff					
		pressure readings,					
	_	assessments/body checks,					
	*	ng charting for client A.					
		body failed to exercise					
		and operating direction					
		's nursing services to					
	_	staff were trained to					
	provide care/tre	eatment of client A and B's					
	health care need	ds. Please refer to W331.					
	The governing	body failed to exercise					
	general policy a	and operating direction					
		to ensure the facility's					
	_	s conducted quarterly					
	_	nents of client B and C's					
	_	d medical needs for 2 of 3					
	-	(clients B and C). Please					
	refer to W336.						
		body failed to exercise					
		and operating direction					
	over the facility	to ensure the facility's					
	nursing services	s trained the facility staff					
	in regard to doc	cumenting blood pressure					
	readings on the	Medication					
	Administration Record (MAR) and to						
		re trained in regard to					
		of the client's daily notes					
		or are enemia during flowers					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G040	B. WIN	G		03/15/	2013
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			300 W 5	53RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ositioning checks, and to					
	_	taff were trained/retrained					
	_	for skin breakdown for 2					
	of 3 sampled clients (clients A and B).						
	Please refer to W342. The governing body failed to exercise general policy and operating direction						
		to have Licensed Nursing					
	1	clients' health needs from					
	2/13/13 until 2/19/13 for 5 of 5 clients						
	(clients A, B, C, D, and E). Please refer to W344.						
	10 W 344.						
	The governing h	oody failed to exercise					
		nd operating direction					
		to ensure a registered					
	1	able to consult and/or					
		l practical nurses to ensure					
		t the health care needs of					
	1	of 5 clients residing at the					
		ents A, B, C, D and E).					
	Please refer to V						
	1 lease letel to V	Y J≒U.					
	The governing b	oody failed to exercise					
		nd operating direction					
		to ensure the facility staff					
	1	e policy and procedure to					
		ications locked when not					
	_	red for 1 of 3 sampled					
	_). Please refer to W382.					
	Choine (choine 11)	j. 113450 10101 to 11 302.					
	The governing b	oody failed to exercise					
		nd operating direction					

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 15/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	ADDRESS, CITY, STATE, ZII 53RD AVE IN 46410	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	over the facility to ensure the facility implemented the agency policy and procedure to have wound care medications labeled for 1 of 3 sampled clients (client A). Please refer to W391. 9-3-1(a)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G040	B. WING		03/15/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	ER		53RD AVE	
ARC OF	NORTHWEST IND	DIANA INC, THE		, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W000125	483.420(a)(3) PROTECTION Of The facility must clients. Therefore and encourage in their rights as clicitizens of the Uright to file comprocess. Based on observinterview, for 1 living at the group facility failed to not obtaining a Resuscitate)/coolegally sanction. Findings included An evening observation client A did not activity during the group home P.M. until 6:30 observation client A did not activity during the A review of client A did not activity during the was conducted. Review of client and indicate a DNR. An interview we Professional (D. 2/27/13 at 5:20.)	DF CLIENTS RIGHTS the ensure the rights of all re, the facility must allow individual clients to exercise tents of the facility, and as inited States, including the plaints, and the right to due wation, record review and of 3 sampled clients out home (client A), the present action was consent from her and representative. The ensure client A's rights by DNR (Do Not de status consent from her and representative. The ensure client A's rights by DNR (Do Not de status consent from her and representative. The ensure client A's rights by DNR (Do Not de status consent from her and representative. The ensure client A's rights by DNR (Do Not de status consent from her and representative. The ensure client A's rights by DNR (Do Not de status conducted at a con 2/27/13 from 4:45 The ensure client A's rights by DNR (Do Not de status conducted at a con 2/27/13 from 4:45 The ensure client A's rights by DNR (Do Not de status conducted at a con 2/27/13 at 5:03 P.M The ensure client A's record did not de status for client A. The ensure client A's record did not de status for client A. The ensure client A's record did not de status for client A. The ensure client A's record did not de status for client A. The ensure client A's rights by DNR (Do Not de status for client A. The ensure client A's rights by DNR (Do Not de status for client A. The ensure client A's rights by DNR (Do Not de status conducted on P.M DSP #2 indicated de status for client A.	W000125	Arrangements for the DNR and Hospice care were made between this clients Legal guardian and Hospice. This clients was in the care of a hospice nurse. Hospice instructed the staff and Service Coordinator not call 911 or perform CPR. Arc NWI failed to obtain the documentation of this agreement. The agreement with obtained on 3/5/13. To ensure future compliance, the Service Coordinator in conjunction with the Nurse will ensure that releases of information are obtained by legal representation and that documentation of car and care plans including DNR obtained. The policy for release of information will be revised to 4/14/13. In addition a work instruction for working with Hospice will be developed so professional staff will have guidance in working with any future clients whom require suservices. To ensure future compliance the behavior Heal Director will audit the files for a clients whom receive Hospice	d 04/14/2013 ient to The vas e h ves e are ses by that that
	2/27/13 at 5:20 staff were instru			Director will audit the files for	any

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
THAD TEAM	or condection	15G040		LDING		03/15/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/10/	
NAME OF F	PROVIDER OR SUPPLIER				53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) er indicated staff were		TAG	obtained within one week of th		DATE
					service beginning.	C	
	instructed they are not to perform CPR (Cardiopulmonary Resuscitation) on client A.						
	CHCIII A.						
	An interview with the Service						
		alified Mental Retardation					
	`	(/QMRP) was conducted					
	,	30pm. The SC/QMRP					
	indicated staff ha	ad been instructed not to					
	call 9-1-1 if something happened to client						
	A. The SC/QMI	RP indicated staff had					
	been instructed r	not to perform CPR on					
	client A. The SC	C/QMRP indicated no					
	DNR/Code Statu	is record was available					
	for review for cli	ient A. The SC/QMRP					
		d not spoken to client A's					
	legally sanctione						
	regarding client	A's code status.					
	A review of clies	nt A's record was					
		facility's administrative					
		3 at 12:15 P.M Client					
		ot indicate a DNR/code					
		A. Further review of the					
		client A was unable to					
	_	onsent and had a legally					
	* *	on maker to assist in					
	_	decisions. There was no					
		n the record to indicate					
		appointed decision					
	_	ONR for client A if she					
	had a change in	code status.					

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		130040	B. WIN		DDDECC CITY CTATE ZID CODE	03/13/2013
NAME OF P	PROVIDER OR SUPPLIER	R			DDRESS, CITY, STATE, ZIP CODE	
	NORTHWEST IND				IN 46410	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	A review of clie	nt A's record was				
	conducted at the	facility's administrative				
	office on 2/28/13 at 12:15 P.M Client					
	A's 12/21/12 hos	spital discharge record				
		d: 12/13/12Diagnoses:				
		dism, Hypercalcemia,				
	_	rtic stenosis, Atrial				
		nic, Cavitary lesion of				
	_	inoma (Cancer) of lung,				
	stage 1."					
	An interview wi	th the Service				
		() was conducted at the				
	· ·	strative office on 3/1/13 at				
		e SC indicated she did				
		documentation a				
		s was obtained in regards				
	to client A.	C				
	0.2.2()					
	9-3-2(a)					

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Facility ID: 000597

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLI	ETED
		15G040	B. WIN			03/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W000149	483.420(d)(1) STAFF TREATMI The facility must of written policies are mistreatment, neg Based on record 1 of 3 sampled of facility neglected policy and proces thorough investig unknown origin. ensure nursing secare needs of click. Findings include 1. A review of the conducted at the office on 2/27/13 of the facility's in reports and Bure Disability Service indicated: BDDS report date Knowledge: 1/2 1/29/13 indicated: BDDS report date Knowledge: 1/2 1/29/13 indicated: Client A] requires foot was cut [Client A] requires foot was cut [Client A] requires follow up on [client follow up on [ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. review and interview for lients (client A), the d to implement written dures to conduct a gation of an injury of The facility neglected to ervices met the health ent A. : the facility's records was facility's administrative at 2:15 P.M Review internal Incident/Accident au of Developmental au of Developmental auses (BDDS) reports ted 1/27/13Date of 7/13Submitted Date: d: "During hospital spital #2 name], [client at. Plan to Resolve: and at least 6 stitches on ent A] is currently in the visiting the hospital for ent A]'s wound care, Jursing staff indicated	Wo	00149	The Behavior Health Director of review reporting and investigate requirements for Abuse Negle (including the neglect of mediciare), Exploitation and injuries unknown origin of clients with Service Coordinator and DSPs that are involved with 53 th Aviby 4/14/13. In order to identify other areas of concern all other Coordinators will be trained or reporting and investigation requirements for Abuse Negle and Exploitation. In order to prevent reoccurrences posters explaining client rights and reporting requirement will be made and distributed to all grown homes and the day program is that staff and clients become more aware of the requirement on an ongoing basis. Additionall staff will be trained on reporting and investigation requirements for Abuse Negle and Exploitation at least annual unless changes occur or need requires this to be done more frequently. To ensure that Serv Coordinators are trained on reporting and investigation requirements for Abuse Negle (including the neglect of medicare), Exploitation and injuries unknown origin the Behavioral Health Director will review their training records at least annual training records and training records at least annual tra	tion ct cal of the se cer ct, sup o ts ally ct; ally rice ct cal of r	04/14/2013
	hospital. While visiting the hospital for follow up on [client A]'s wound care, [Hospital #2]'s Nursing staff indicated that [client A] sustained an injury during				care), Exploitation and injuries unknown origin the Behavioral	of r	

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013		
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	transportation to the hospital. Sometime after [client A] left the group home and before she arrived at the hospital [client A] hit her second toe on her left foot in transport. There is no report from the paramedic as to specifically what she hit her toe on but it is suspected that the transport gurney bed rails were involved per hospital staff. The paramedics immediately reported the injury to the hospital staff and at least 6 stitches were needed to close the wound. No staff were suspended and no internal investigation can be completed as she was not in The Arc NWI (Northwest Indiana) care at the time of the injury. It was previously reported the [client A] was being transported for shortness of breath, this was the primary focus of medical staff, and additional documentation of this injury is not available for review but no abuse is suspected based on the reporting from Paramedics and the care she received while in the ER." A review of client A's record was conducted at the facility's administrative office on 2/28/13 at 12:15 P.M Review of client A's medical record indicated the following: Nursing notation dated 1/28/13: "While doing a body check it was found that [client A] had a deep cut on her foot that		and document review of findin Area Managers will review DS training records to ensure the have been training at least annually and document review findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for Abuse Neglect (including the neglect of medical care), Exploitation and injuries of unknown origin prior to workin home or with a client. In addit the Service Coordinators will I present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, e Documentation of visits will be completed and will include specifics to the client as well at the visit. The Behavioral heal Director will review progress notes regularly.	g a cion, pe t c.		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	00,10,2010
NAME OF	PROVIDER OR SUPPLIEI	₹		53RD AVE	
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	transport. Six st	curred during ambulance itches were required to . Investigation initiated."			
	incident/acciden and investigation was made on 2/2 Service Coordin	at for any Internal t reports, BDDS reports as for this group home 27/13 at 3:00 P.M The ator (SC) stated "That's are were no investigations ome."			
	records was mad	For any investigation de on 3/1/13 at 11:15 tigation records were view.			
	3/1/13 at 11:45 A "There wasn't ar because it happe and was found a asked if the facil the injury occur happened some ambulance picke the hospital. We caught in the sid there was docun review to indicat thorough investi	th the Service (2) was conducted on A.M The SC stated in investigation done ened on the ambulance at the hospital." When lity knew when and how ared, the SC stated "It time between when the ed her up and getting to the believe her foot got the rails." When asked if mentation available for the she had conducted a gation of the incident, the ed did not have written o indicate she conducted			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G040	A. BUII B. WIN	LDING		03/15/	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			300 W 5	53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY, I	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		because the incident		mo			DATE
	_	ay program. The SC					
		ormation was available for					
	review to determine the place of origin where the unknown injury occurred.						
		he facility's records was					
		facility's administrative					
		3 at 2:15 P.M Review					
	-	nternal Incident/Accident au of Developmental					
	_	-					
	Disability Services (BDDS) reports indicated:						
	marcatea.						
	-Internal inciden	t/accident report dated					
	1/3/13 at 6:30 A	.M.: "Received a call					
	from group hom	e staff that the consumer's					
	blood pressure w	vas low. I informed staff					
		B/P (blood pressure)					
	medications unti						
	_	(sic) Health and Safety					
		her B/P. Blood pressure					
		y the Health /Safety					
		r blood pressure was low. called to transport her to					
		call (Hospital initials) for					
	evaluation and tr						
		ou think could prevent					
	` ′ •	this Incident/Accident?					
		o follow instructions and					
		on to what they are doing.					
		in he way they should be					
		tion Taken: Consumer					
	was sent to the E	ER (Emergency Room) @					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G040	B. WIN	G		03/15/	2013
NAME OF I	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					53RD AVE		
ARC OF	NORTHWEST INC	DIANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	- 1] for evaluation and					
		her review of the report					
	_	licate a licensed medical					
	staff checked cl	ient A's blood pressure					
	and further negl	ected to indicate what					
	client A's blood	pressure readings were.					
	The report did r	not indicate whether or not					
	the facility staff	had administered client					
	A's morning me	edications for blood					
	pressure.						
	-Internal incide	nt/accident report dated					
		A.M.: "Health Safety tech					
		From the Nurse stating an					
		be coming to take (client					
		al. Got [client A] ready to					
	go to hospital."	ui. Got [elicht 11] ready to					
	go to nospital.						
	A review of clie	ent A's record was					
		e facility's administrative					
		3 at 12:15 P.M Review					
		dical record indicated the					
	following:	dicar record indicated the					
	Tollowing.						
	-Nursing notation	on dated 9/26/12:					
	_	had a cough off and on for					
		•					
		n month will refer her to					
		ASAP (As Soon As					
	Possible).						
	Nurgina natati	on dated 1/2/12:					
	-Nursing notation						
	_	one call from group home					
	on 1/2/13 DSP (• • •					
	Professional) sta	ated that consumers B/P					

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI - 03/15	LETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	ddress, city, state, zip co 53RD AVE IN 46410	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	had been low and they had client to relax and B/P was retaken and they gave her blood pressure medications. I advised staff to monitor client during the night for any adverse affects. Call me in the morning. Check B/P (Blood Pressure) before giving her medication." No documentation was available for review to indicate what client A's B/P readings were. No documentation was available for review to indicate the facility's licensed nursing staff assessed client A on 1/2/13 after staff notified them of her health status. -Nursing notation dated 1/3/13: "Received a phone call from group home DSP stated her (client A)'s B/P was 85/82 Pulse 53. I advised staff to not give her B/P medications and to bring her blood pressure medication Metoprolol 50 mg (milligram) to the workshop with her and give it to the H and S Tech. While at the workshop her B/P was left arm 69/33 and right arm 78/42. I called for [Name of Hospital] Ambulance to transport client to the ER-[Name of Hospital] for evaluation and treatment. Ambulance arrived at the [Day Program name] to transport client to the ER." No documentation was available for review to indicate the facility's licensed nursing staff assessed client A for her health status.				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL	
ANDILAN	OF CORRECTION	15G040	A. BUI	LDING	00	03/15/	
		130040	B. WIN			03/13/	2013
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			53RD AVE IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-Nursing notation	n dated 1/23/13: "[Client					
	A] was discharge	ed from the hospital					
	todayUpon rec	eiving a post hospital					
	assessment it wa	s found that [client A]					
	has 3 areas of co	ncern on her body. A					
	decube (an open	sore on the skin) on her					
	left buttock, a sn	nall open area on her left					
	chest and a smal	l area of concern between					
	her toes. [Client	A] will be seen at the					
	wound clinic on	1/29/13 to address all					
	wounds. [Client	A] also came home with					
	a pacemaker/def	ibrillator. A machine					
	was sent to the h	ouse to be placed by her					
	bed which will n	nonitor her from midnight					
	until 6 A.M7 da	ays a week. [Client A] is					
	still a bit weak fi	com being in the hospital					
	and will require	staff to assist her with					
	transports until s	he is steady on her feet.					
	[Client A] will re	emain home until after					
	she is seen at the	wound clinic on					
	1/29/13." There	was no documentation in					
	the record to ind	icate the facility's nursing					
	staff developed r	risk plans to address					
	client A's docum	ented health concerns in					
	_	eakdown, recording of					
	blood pressure re	eadings, to completed					
	skin assessments	s/body checks, and to					
	reposition client	A.					
	A request to inte	rview the facility's					
	_	Registered Nurse (RN)					
	_	/13 at 12:15 P.M The					
		strator indicated there was					
	-	available for interview.					
							<u> </u>

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		15G040	B. WIN	G		03/15/	2013
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			33RD AVE IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A request for tele						
		made but none was					
	_	inistrator (non licensed					
	· · · · · · · · · · · · · · · · · · ·	ated "I can answer any					
		ve." When asked why					
		vait on $1/2/13$ (when the					
	U 1	f called to report client					
	•	essure), and again on					
		am (when the group					
		eport client A's low blood					
	•	d time) until 9:40am,					
		ived at workshop to have					
		lled to transport her to					
	-	Administrator indicated					
		called for an ambulance					
	for client A's trar	nsportation to the					
	hospital. No add	litional information was					
	provided. When	asked if the facility's					
	nursing services	were meeting the					
	identified health	care needs of client A in					
	regard to oversee	eing and monitoring her					
	-	ssing client A's skin					
	breakdown, deve	eloping risk plans,					
	ensuring the facil	lity staff recorded blood					
	pressure readings	s, completed skin					
	assessments/body	y checks, and					
	repositioning cha	arting for client A, the					
	Administrator die	d not respond to the					
	question.						
	On 3/15/13 at 5:1	18pm, an interview with					
	the Behavior Hea	althcare Director (BHCD)					
	was conducted.	The BHCD indicated the					
	agency was work	king to resolve client A's					
			1				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION	(X3) DATE (COMPL	
ANDILAN	or connection	15G040		LDING	00	03/15/	
		100040	B. WIN			03/13/	2010
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			53RD AVE IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e oversight for client A's					
		s. The BHCD indicated					
		nave documented					
	_	r health care status,					
		kin breakdown, risk plans					
	_	mented blood pressure					
	readings, comple						
	assessments/bod						
	_	a repositioning schedule					
	for client A.						
		facility's "Policy for					
	_	of Neglect and Abuse"					
		vas completed at the					
	_	strative office on 2/28/13					
	•	l indicated: "In order to					
		al welfare of the clients,					
		Indiana has in effect the					
		with regard to abuse,					
		tation of clients by					
		ohibits all abuse, neglect					
	•	of our clientsStaff will					
		ort any allegations of					
	, ,	exploitation of our					
	clients per agenc						
	procedureNegl						
	0 7 1	ng a client in a situation					
	•	at to his/her health and					
	_	mples include, but are not					
	_	ying a client of food,					
	clothing, shelter	or medical care."					
	On 2/27/13 at 2:	30pm, a review was					
	completed of the	-					
		•					

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." 9-3-2(a)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410 ID PROVIDERS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) OCMPLETION DATE (X5) (COMPLETION DATE OCMPLETION DATE	AND PLAN	OF CORRECTION			00			
ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX TAG Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." 300 W 53RD AVE GARY, IN 46410 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION) DATE OMPLETION DATE TAG OMPLETION DATE OMPLETION DATE OMPLETION DATE OMPLETION DATE			100070		ADDRESS STEEL STEE	00/10/2010		
ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." (X5) PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DOMPLETION DATE **COMPLETION D	NAME OF P	PROVIDER OR SUPPLIE	₹					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." PREFIX TAG TAG PREFIX TAG PREFIX TAG TAG TAG PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	ARC OF							
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." CROSS-REFERENCED TO THE APPROPRIATE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE COMMENTS. TAG CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE COMMENTS. TAG CROSS-REFERENCED TO THE APPROPRIATE COMMENTS. TAG CROSS-REFERENCED TO THE APPROPRIATE COMMENTS. DATE					PROVIDER'S PLAN OF CORRECTION			
Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."					CROSS-REFERENCED TO THE APPROPRIA	IE		
and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."	1710		·	1710		DATE		
policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."		_	_					
supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."								
emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."			_					
available and offered and such failure results in physical or psychological harm to the individual."								
results in physical or psychological harm to the individual."		although sources	s of such support are					
to the individual."								
9-3-2(a)		to the individual	."					
9-3-2(a)		0.2.2(a)						
		9-3-2(a)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	ETED
		15G040	B. WIN			03/15/2	2013
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			300 W	53RD AVE		
	NORTHWEST INDI				IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO TH		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE	
W000154	The facility must I alleged violations investigated.		Wo	00154			04/14/2012
	facility failed for unknown origin, clients (client A)	involving 1 of 3 sampled to provide evidence a gation was completed.	W0	00154	The Behavior Health Director of review reporting and investigated requirements for Abuse Neglet (including the neglect of mediciare), Exploitation and injuries unknown origin of clients with the Service Coordinator and DSPs that are involved with 53 th Averby 4/14/13. In order to identify	tion ct cal of the s	04/14/2013
	conducted at the office on 2/27/13 of the facility's in reports and Bure	facility's records was facility's administrative B at 2:15 P.M Review internal Incident/Accident au of Developmental ies (BDDS) reports			other areas of concern all other Coordinators will be trained on reporting and investigation requirements for Abuse Neglec and Exploitation.In order to prevent reoccurrences posters explaining client rights and reporting requirement will be made and distributed to all growhomes and the day program so		
	Knowledge: 1/2 1/29/13 indicated transport to [Hos A]'s foot was cut [Client A] requir her left toe. [Clihospital. While follow up on [cli [Hospital #2]'s N that [client A] su transportation to after [client A] left	ted 1/27/13Date of 7/13Submitted Date: d: "During hospital spital #2 name], [client pital			that staff and clients become more aware of the requiremen on an ongoing basis. Addition all staff will be trained on reporting and investigation requirements for Abuse Neglet and Exploitation at least annual unless changes occur or need requires this to be done more frequently. To ensure that Serv Coordinators are trained on reporting and investigation requirements for Abuse Neglet (including the neglect of medic care), Exploitation and injuries unknown origin the Behavioral Health Director will review thei training records at least annual	ally ct, ally ice ct cal of	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
ANDILAN	or connection	15G040		LDING		03/15/	
		100010	B. WIN		A PARAGO CHEMA CHEMA CAN CONT.	33/13/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	and document review of findin		DATE
	_	d toe on her left foot in			Area Managers will review DS		
	_	is no report from the			training records to ensure they		
	. ^	specifically what she hit is suspected that the			have been training at least	4	
		bed rails were involved			annually and document review findings. All new Service	OI	
		The paramedics			Coordinators and DSPs will be)	
		orted the injury to the			trained on reporting and		
		d at least 6 stitches were			investigation requirements for Abuse Neglect (including the		
	_	the wound. No staff were			neglect of medical care),		
		o internal investigation			Exploitation and injuries of		
	-	d as she was not in The			unknown origin prior to workin		
	_	west Indiana) care at the			home or with a client. In addit the Service Coordinators will be		
	`	y. It was previously			present in their homes at least		
	reported the [clie	•			two times per month to ensure		
	_	hortness of breath, this			protection of clients, address		
	_	focus of medical staff,			concerns, monitor activities, effortion Documentation of visits will be		
		ocumentation of this			completed and will include		
	injury is not avai	lable for review but no			specifics to the client as well a		
	l " •	ed based on the reporting			the visit. The Behavioral healt Director will review progress	h	
	_	s and the care she			notes regularly.		
	received while in	n the ER."					
	A review of clien	nt A's record was					
	conducted at the	facility's administrative					
	office on 2/28/13	3 at 12:15 P.M Review					
	of client A's med	lical record indicated the					
	following:						
	Nursing notation	dated 1/28/13: "While					
	doing a body che	eck it was found that					
	[client A] had a	deep cut on her foot that					
	had possibly occ	urred during ambulance					
	•	itches were required to					
	close the wound.	Investigation initiated."					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 15/2013
	PROVIDER OR SUPPLIER		300 W 5	address, city, state, zip 53RD AVE IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	incident/acciden and investigation was made on 2/2 Service Coordin everything. The for this group has a third request for records was made A.M No investigation was documentation to an investigation occurred at the coindicated no inforce in the control of the coordination occurred at the coindicated no inforce in the coindicated no inforce in the coindicated in the coindicated no inforce in the coindicated i	For any investigation de on 3/1/13 at 11:15 tigation records were view.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G040	B. WIN			03/15/	2013
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			53RD AVE		
ARC OF	NORTHWEST INDI	IANA INC. THE			IN 46410		
						1	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG W000217		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE
VVUUU217	483.440(c)(3)(v) INDIVIDUAL PRO	OGRAM PLAN					
		ive functional assessment					
	must include nutri						
		ation, record review, and	- $ $ $ $ $ $ $ $ $ $ $ $ $ $	00217	This client was receiving hospi	ce	04/14/2013
		cility failed to assess the		'	care. Hospice was keeping all	- =	
	· ·	1 of 3 sampled clients			documentation of this client's		
	1	1 of 5 sampled chefts			medical care. The Hospice		
	(client A).				provider agency stated they di		
					not document any intake/outpu		
	Findings include	: :			records for this client as it was		
					practical due to terminal illness The IDT will review Nutritiona		
	An evening obse	ervation was conducted at			health, developmental and	11,	
	the group home	on 2/27/13 from 4:45			other assessments as they a	re	
	• •	P.M. During the entire			received or at least annually		
		od client A lay in her bed.			compare them to Client goals		
	•	eat or drink anything.			and risk plans to ensure that		
	Chent A did not	eat of drink anything.			areas of need are being		
					addressed. The Behavior		
		nt A's group home record			health director or designee w	rill	
	was conducted o	n 2/27/13 at 5:35 P.M			perform a random audit of		
	Review of the re	cord did not indicate an			client files at least quarterly t	0	
	intake/output cha	art. There was no			ensure that emerging client		
	documentation a	vailable for review to			needs are being addressed b	У	
	indicate the facil	ity documented food and			the team.		
		output for client A.					
	Traid intake and v	output for elient 14.					
		41 D: 4 C					
		th Direct Support					
	` `	SP) #2 was conducted on					
		P.M DSP #2 stated					
	client A "appears	s to have lost a lot of					
	weight because s	sometimes she won't eat."					
	When asked if st	aff charted her					
		e and output, DSPs #1					
	and #2 indicated						
		they did not.					
	A rovious of alice	nt A's record was					
	A TEVIEW OF CITE	iii A s iecuiu was	1				

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	A. BUII	LDING	00	COMPL	ETED
		150040	B. WIN			03/15/2013	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	300 W 53RD AVE GARY, IN 46410				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		facility's administrative					
		at 12:15 P.M Review					
		tritional Assessment"					
	dated 4/20/12 inc	dicated she was on a Low					
	Cholesterol weig	ht reduction diet. The					
	assessment indicate	ated her weight was 146					
	pounds. Review	of client A's hospital					
	discharge record	dated 12/21/12					
	indicated: "Filed	l: 12/13/12Diagnoses:					
	Hyperparathyroid	dism, Hypercalcemia,					
	Weight loss, Aor	tic stenosis, Atrial					
	fibrillation chron	ic, Cavitary lesion of					
	lung, Adenocarci	inoma of lung, stage					
	1Current Diet I	Prescribed: Cardiac,					
	Ground, Ensure	Complete BID (twice					
	-	50 kg (kilograms) (110					
		review of client A's					
		dicate a more current					
		essment" after client A's					
	weight loss.						
	Weight less.						
	An interview wit	h the Service					
) was conducted at the					
	` /	strative office on 3/1/13 at					
	_	en asked if client A was					
		ess her weight and body					
	further indicated	C stated "No." The SC					
	•	art in place for client A.					
		ndicated the 4/20/12					
		essment" was the most					
		nt available to staff. No					
	nursing staff was	available for interview.					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 03/15	LETED 5/2013	
	PROVIDER OR SUPPLIE NORTHWEST IND	DIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION IN SHOULD BE HE APPROPRIATE)	(X5) COMPLETION DATE	
IAU	9-3-4(a)	X LOC IDENTIFICING INFURMATION)				DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		15G040	B. WIN			03/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000227	483.440(c)(4) INDIVIDUAL PRO The individual pro specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on observe record review for (client C), the fact professional record C's prescribed he address client C's communication of Findings include On 2/27/13 from client C was obse with Group Hom and #3 and client prescribed hearing the dining room, and walked throug independently wo GHS #1, GHS #2 talk to client C the to the room the s in. Client C sat,	ogram plan states the serious necessary to meet the identified by the sessessment required by of this section. ation, interview and reference to follow a serious aidentified to follow a serious aidentified to serious aidentified need. 4:05pm until 6:15pm, erved at the group home are Staff (GHS) #1, #2,	W0	00227	This client had and audio logic evaluation on 3/11/13 an ABR scheduled for 4/29/13. If need an appointment for a fitting will occur by 5/31/13 have If in fact hearing aids are still a recommendation, a goal will be put in place to desensitize cliet to wearing them. The IDT will review Audio logical, Nutritional, health, developmental and other assessments as they are received or at least annually compare them to Client goals and risk plans to ensure that areas of need are being addressed. The Behavior health director or designee we perform a random audit of client files at least quarterly the ensure that emerging client needs are being addressed be the team.	is led l t e nt to s all	04/14/2013
	Client C's record 11:20am. Client	l was reviewed 3/1/13 at C's 7/23/12 ISP					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	A. BUI	LDING	NSTRUCTION 00		E SURVEY LETED 5/2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP COI		
NAME OF F	PROVIDER OR SUPPLIER	L			53RD AVE)L	
ARC OF	NORTHWEST INDI	IANA INC, THE			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APP CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
		port Plan) did not indicate					
		objective. Client C's					
	7/23/12 ISP indi	C					
		diologist 6/23/06 (2006)					
		tried many forms of					
		unable to consistently					
	_	on, all forms tried with					
		le to wear amplification,					
		nunicate with one to one					
		hout amplification, is icate with staff and					
		en verbal cues, and					
		, IDT (Interdisciplinary					
		2009) discussed agreed					
	` ′	ware and communicate					
		her decline." Client C's					
		rom the hearing clinic					
		C "was seen on 8/4/2011					
		testing. Results of that					
	,	e) report indicated [client					
	_	earing aids in both ears					
		most recent set of hearing					
	_	d from the clinic in C's 8/4/11 auditory					
		ated "suspect mild e SNHL (hearing) in at					
	least 1 (one)	Sivile (nearing) in at					
	` ′	dation:discussed					
		idacy with Service					
	Coordinator." C	-					
	*	er" indicated "hearing					
		orning, check placement & store in an unlocked					
	area at HS (night	t). Change Hearing Aid					

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	of Correction identification number: 15G040	A. BUILDING B. WING	<u>00</u>	COMPLETED 03/15/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 V	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	On 3/1/13 at 12:15pm, an interview with the SC was conducted. The SC indicate client C did not wear hearing aids and d not have hearing aids available to wear. The SC indicated she was unaware of the 8/2011 recommendation made by the audiologist and was unaware of client C physician's order to wear hearing aids. The SC indicated client C did not have a goal/objective for her lack of prescribed hearing aids. 9-3-4(a)	ed id ne ''s					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		15G040	B. WING	o .		03/15/	2013
		_	_	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIE	R	30	00 W 5	3RD AVE		
	NORTHWEST IND				N 46410		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA	UG	DEFICIENCE)		DATE
W000248	be made availab including staff of with the client, and the client is a min Based on observation observation. Based on observation interview, the fas sampled clients ensuring the clients ensuring the client Support Plan) and Plans (BSP) were home. Findings included On 2/27/13 from P.M. observation conducted at the Group Home Station of the client B and C's Plans) and BSPs Plans) were not home for staff to until 6:15pm, client Band Band C's Plans) were not home for staff to until 6:15pm, client Band Band Band Band Band Band Band Band	lient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if mor) or legal guardian. Vation, record review, and icility failed for 2 of 3 (clients B and C) by not ents' ISPs (Individual and Behavior Support re available at the group	W00024	48	ISPs and BSPs will be sent outhe group home by 4/14/13. The Service Coordinator will audit a group home files and will ensuthat Day program files, and family/guardians have necessed documentation is available to a relevant staff, families and day program. To ensure future compliance, the Service Coordinator and Individual Program Coordinator will work together to ensure that all ground homes have the documentation necessary to be informed of each clients' needs.	ne all re ary all ip n	04/14/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G040	B. WIN		-	03/15/2013	
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		300 W 5	53RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE			IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	each time, and d	id not communicate with					
	staff.						
	An interview wi	th the Service					
	Coordinator (SC	() was conducted on					
	`	A.M The SC indicated					
	client B's ISP was not available at the group home for staff to reference.						
	group nome for	Starr to reference.					
	Client Dia	l was reviewed at the					
	" "	13 at 12noon. Client B's					
	`	lividual Support Plan)					
		objectives to wear her					
	^	lasses, make a purchase,					
	exercise 20 minu	utes, complete her					
	personal hygiene	e, make change from					
	\$2.00, straighten	her bureau, prepare					
	simple item for o	cooking, and learn the six					
		ation administration.					
	~	l indicated she had a					
		t plan and no plan was					
	available for rev	-					
		10 W .					
	On 3/1/12 of 11.	10am an interview with					
		10am, an interview with					
		rdinator (SC) was					
		SC indicated client B had					
		and neither were at the					
		ilable for staff to use on					
	2/27/13.						
	<u></u>						
		d was reviewed 3/1/13 at					
	11:20am. Client	t C's 7/23/12 ISP					
	(Individual Supp	oort Plan) indicated					
	goals/objectives	to identify a penny and					

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMI	E SURVEY PLETED 5/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	quarter, to choose a healthy snack, to identify her medication by name and type, to set the water temperature for comfort level, to dry herself after bathing, and to brush her teeth.						
	On 3/1/13 at 12:15pm, an interview with the SC was conducted. The SC indicated client C's 7/23/12 ISP was not available at the group home for staff to reference.						
	9-3-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		15G040	B. WING		03/15	/2013
NAME OF B	DOLUMEN OR GUINN HER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L	300	W 53RD AVE		
	NORTHWEST INDI			RY, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W000249	483.440(d)(1) PROGRAM IMPL					
		terdisciplinary team has nt's individual program plan,				
		receive a continuous active				
		n consisting of needed				
		services in sufficient				
		uency to support the				
	achievement of the objectives identified in					
	the individual pro	gram plan. ation, record review, and	W000249	The Service Coordinator w	iii	04/14/2013
			W 000249	retrain DSPs on implemen		04/14/2013
	· ·	of 3 sampled clients		of objectives for all consur		
), the facility failed to		53 rd and active treatment		
	implement client			Training will also be docur	nent by	
		when opportunities		4/14/13. To ensure future		
	existed.			compliance, the Service Coordinator will observe		
	Findings include	::		implementation of the prog objectives weekly for three consecutive months and		
	On 2/27/13 from	4:05 P.M. until 6:15		bimonthly thereafter. The		
	P.M. observation	and interviews were		Behavior Health Director v		
		group home. Client B		with the Service Coordinat weekly to discuss any con		
		out the group home,		with program implementat		
	_	oom, bedrooms, and		staff training.	-	
		From 4:05pm until				
	_	sat with Group Home				
		#2, and #3 and client C				
	· · ·	scribed hearing aids.				
	•	ne dining room, sat in the				
		walked throughout the				
		ependently without				
	_	me GHS #1, GHS #2, and				
		to talk to client C the				
		alked to client C and				
		the hand to the room the				
	staff wanted clie	nt C to sit in. Client C				

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY SPLETED 15/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	sat, smiled at the speaker each time, and did not communicate with staff. At 5:12pm, client B gathered her laundry in her bedroom, carried the dirty laundry to the washer, put the laundry inside, and client B called for GHS #1. At 5:30pm, GHS #1 walked to the laundry room, client B placed a shirt into the washer, GHS #1 measured the soap, and GHS #1 placed the soap into the washer. GHS #1 stated clients "were not allowed" to use the washer because it was "new." At 5:30pm, client B walked to the kitchen without washing her hands and was prompted by GHS #2 to set the table. At 5:42pm, GHS #2 administered client B's Beneprotein Power. GHS #2 scooped the medication from its container, mixed the medication with water, and client B drank the mixture. Client B did not name the medication. From 6:00pm until 6:15pm, client B stood to serve herself foods from the plates and containers off the table for supper. Client C was not prompted for activity during the entire observation. Client B's record was reviewed at the agency on 2/28/13 at 12noon. Client B's 7/19/12 ISP (Individual Support Plan) indicated goals/objectives to wear her prescribed eye glasses, make a purchase, exercise 20 minutes, complete her personal hygiene, make change from \$2.00, straighten her bureau, prepare						

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Event ID: PDMX11

Facility ID: 000597

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 15/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	simple item for cooking, and learn the six rights for medication administration. Client B's record indicated she had a behavior support plan and no plan was available for review.						
	Client C's record was reviewed 3/1/13 at 11:20am. Client C's 7/23/12 ISP (Individual Support Plan) indicated goals/objectives to identify a penny and quarter, to choose a healthy snack, to identify her medication by name and type, to set the water temperature for comfort level, to dry herself after bathing, and to brush her teeth. On 3/1/13 at 12:15pm, an interview with the SC was conducted. The SC indicated clients B and C should have been prompted for active treatment and ISP goals/objectives should have been implemented when opportunities existed. 9-3-4(a)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DUPLED INC. 00			COMPL		
		15G040	A. BUII B. WIN			03/15/	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CROSS-REFEREN		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ESC IDENTIFTING INFORMATION)		IAG			DATE
W000318	483.460 HEALTH CARE S The facility must e care services reques assed on record Condition of Part Services, was not to provide health oversight of nurs sampled clients (two additional cl Findings include Please refer to W nursing services healthcare needs the client A's hea client A's skin br risk plan specific need of client A, recorded blood p	SERVICES ensure that specific health uirements are met. review and interview, the ticipation: Health Care t met as the facility failed care monitoring and ing services for 3 of 3 clients A, B, and C) and ients (clients D and E). Can be facility's failed to meet client A's in regard to monitoring alth needs, assessing eakdown, developing a to meet the health care ensuring the facility staff	WO	00318	CONDITION- Please refer to a w331, w336, w342, w 344, w346, 382, w391	tags	04/14/2013
	and repositioning The facility's nur	g charting for client A. sing services failed to trained to provide Celient A and B's					
	to conduct quarte of client B and C	7336. The facility's failed erly nursing assessments "s health status and r 2 of 3 sampled clients".					

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Event ID: PDMX11

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If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 03/15	
	PROVIDER OR SUPPLIER			300 W 5	ddress, city, state, zip code 3RD AVE N 46410	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE TO THE APPRODE TO THE APPRODE TO THE APPRODE TO THE APPROPRIEST OF THE APPRO	D BE	(X5) COMPLETION DATE
	Please refer to We nursing services were trained in reducation Adm (MAR) and to ended to declare and E), to have I care for clients and E). Please refer to We nursing services registered nurse and/or oversee liensure nursing services and/or oversee liensure nursing services and the cliensure for the cliens at the graph of the cliens at the graph of the cliens are fer to We to ensure the cliens are fer to We to e	failed to ensure staff egard to documenting eadings on the aninistration Record asure staff were trained in entation of the client's or body/repositioning asure facility staff were to provide care for skin of 3 sampled clients). 7344. The facility's failed for 5 of 5 clients ome (clients A, B, C, D, Licensed Nursing staff to nealth needs from 2/13/13 7346. The facility's failed to ensure a was available to consult censed practical nurses to taff met the health care ants for 5 of 5 clients roup home (clients A, B, C) 7382. The facility failed ent's medications were an not being readied for					
	administration for (client A).	or 1 of 3 sampled clients					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040			ILDING	COMPLETED 03/15/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	for 1 of 3 sample have wound care	V391. The facility failed ed clients (client A), to e medications labeled.						
	9-3-6(a)							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00				SURVEY ETED	
THYDTEMY	or conduction	15G040	A. BUII			03/15/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00, 10,	
NAME OF P	ROVIDER OR SUPPLIER				53RD AVE		
	NORTHWEST INDI	ANA INC, THE			, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W000331	483.460(c)	ESC IDENTIF TING INFORMATION)		IAG			DATE
	NURSING SERVI The facility must p services in accord Based on observa record review, fo (clients A and B)	provide clients with nursing dance with their needs. ation, interview, and or 2 of 3 sampled clients of the facility's nursing	W0	00331	Please see W 102, W 104, an W 217	d	04/14/2013
	clients in regard	meet the needs of the to monitoring each					
		eds, assessing client A's					
	-	developing a risk plan					
	*	the health care needs of					
	recorded blood p	g the facility staff					
	-	ssessments/body checks,					
	•	g charting for client A.					
		rsing services failed to					
	_	trained to provide					
	care/treatment of	•					
	healthcare needs.						
	Findings include	:					
	client A was layi and required staf Home Staff (GH	om 4:05pm until 6:15pm, ng in her hospital bed, if assistance from Group S) #1, GHS #2, and GHS d. Client A was non					
	conducted at the office on 2/27/13 of the facility's in	facility's records was facility's administrative 3 at 2:15 P.M Review nternal Incident/Accident au of Developmental					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		LDING	NSTRUCTION 00	(X3) DATE COMPI 03/15	LETED
	PROVIDER OR SUPPLIER		p. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE 33RD AVE IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Disability Service indicated for clie	es (BDDS) reports ent A:					
	1/3/13 at 6:30 A. from group home blood pressure we to with hold her medications until workshop. I ask Tech to recheck was rechecked be Tech. Consumer Ambulance was [Name of Hospit treatment. What could prevent red Incident/Accident follow instruction to what they are in he way they shad B-Action Taken: the ER (Emergent Hospital] for evaluation for evaluation to the example of t	t/accident report dated .M.: "Received a call e staff that the consumer's vas low. I informed staff B/P (blood pressure) l she gets to the (sic) Health and Safety her B/P. Blood pressure y the Health /Safety r blood pressure was low. called to transport her to call for evaluation and measure(s) do you think occurrence of this nt? Staff need (sic) to ns and pay close attention doing. Give medication hould be done. Part c Consumer was sent to ncy Room) @ [Name of aluation and treatment. If the report failed to ed medical staff checked pressure and what client re readings were. t/accident report dated .M.: "Health Safety tech om the Nurse stating an the coming to take (client l. Got [client A] ready to					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
		15G040	A. BUILDING B. WING	00	03/15/2013
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R		53RD AVE	
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG	go to hospital."	<u> </u>	TAG	BELLEVELY	DATE
	1	available for review to			
		lity's licensed medical			
		assessed client A.			
	starr physically	assessed elicit 11.			
	-BDDS report d	ated 1/27/13Date of			
	Knowledge: 1/2	27/13Submitted Date:			
	1/29/13 indicate	d: "During hospital			
	transport to [Ho	spital #2 name], [client			
	A]'s foot was cu	t. Plan to Resolve:			
	[Client A] required at least 6 stitches on				
	her left toe. [Cl	ient A] is currently in the			
	hospital. While	visiting the hospital for			
	follow up on [cl	ient A]'s wound care,			
	1 2 2	Nursing staff indicated			
		ustained an injury during			
		the hospital. Sometime			
	1	eft the group home and			
		ed at the hospital [client			
		d toe on her left foot in			
		e is no report from the			
	1 ^	specifically what she hit			
		is suspected that the			
	1	bed rails were involved			
		f. The paramedics			
	1 -	oorted the injury to the			
	_	d at least 6 stitches were			
		the wound. No staff were			
	_	no internal investigation			
		ed as she was not in The			
	`	nwest Indiana) care at the			
	1	y. It was previously			
		ent A] was being			
	transported for s	shortness of breath, this			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	ĺ	LDING	NSTRUCTION 00		SURVEY LETED 5/2013
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO S3RD AVE IN 46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	was the primary and additional do injury is not availabuse is suspected from Paramedices received while in information was. A review of client conducted at the office on 2/28/13 of client A's medical following: -Nursing notations asys her lower do get Medicaid and denture, we need resulting in the losigned by one of Practical Nurses documentation to dentures were resulting notations. "Consumer has happroximately a see the doctor At Possible). There	focus of medical staff, ocumentation of this lable for review but no ed based on the reporting and the care she in the ER." No follow up available for review. In A's record was facility's administrative at 12:15 P.M Review lical record indicated the in dated 4/30/12: "Patient enture was lost. In order approved for a new late know circumstances coss." This notation was the facility's Licensed (LPN). There was no indicate client A's lower placed. In dated 9/26/12: and a cough off and on for month will refer her to SAP (As Soon As was no documentation		TAG	DEFICIENCY)		DATE
	the doctor prior to -Client A's lab le 10/24/12 and res	redicate client A went to to 10/12/12. Evels date of collection ults faxed to the facility cated: "CreatineOut of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		A. BUILDING B. WING			COMPLETED 03/15/2013		
		100010	B. WIN			00/10/	20.0
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			53RD AVE IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	•	Ference Range 0.60-0.93					
	mg (milligrams).	For patients >49 years					
	of age, the refere	ence limit for Creatine is					
	approximately 13	3% higher for people					
	identified as						
	African-America	nCalciumOut of					
	Range 11.3Ref	erence Range					
	8.6-10.4Parath	yroid HormoneOut of					
		rence Range 10-65."					
	There was no do	cumentation in the record					
	to indicate if the facility's nursing services						
	contacted the doctor and sought medical						
		nt A in regards to her					
	high levels until	-					
	mgn revers until	uttor 10/31/12.					
	-Nursing notation	n dated 10/31/12:					
	_	be admitted to [Name of					
		percalcemia (high					
	calcium levels in						
		nonitoring) per [Doctor's					
	`	O / 1					
	_	R visit was canceled per					
	-	orders due to hospital					
	does not have an						
		's lab levels are elevated.					
		Creatine 1.17, Calcium					
	11.3, Parathyroid	l Hormones 88."					
	37	1 . 1 1 1 /0 /10					
	-Nursing notation						
		mitted to [Name of					
		s on telemetry unit due to					
	history of Hypero	calcemia."					
	-Nursing notation	n dated 11/15/12·					
	"Consumer was p						
			1				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 15/2013
	PROVIDER OR SUPPLIER		STREET 300 W	ADDRESS, CITY, STATE, ZIF 53RD AVE IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	A Diagnosis of I to why consume on 11/8/12 after surgery table her she will be seen specialist"					
	_	n dated 11/23/12: "She BT's (Intravenous in TB isolation."				
	-Nursing notation dated 11/26/12: "She remains in TB isolation."					
	dated 12/21/12 is these medication mgTake 1 tabl Review of Isonia antibiotic used to bacteria from mo of client A's reco- client A had acti	et by mouth daily." azid indicated it is an be keep tuberculosis altiplying. Further review ord did not indicate if we TB or a history of TB was isolated on the TB				
	"Lung biopsy	n dated 11/29/12: noted to show that she denocarcinoma (lung				
l	-Nursing notatio	n dated 1/3/13:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G040	B. WING		03/15/2013
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	R		53RD AVE	
ARC OF	NORTHWEST IND	IANA INC. THE		IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		,	TAG	DEI ICERCI)	DATE
	_	ne call from group home			
	on 1/2/13 DSP (Direct Support				
	· · · · · · · · · · · · · · · · · · ·	ated that consumers B/P			
	had been low an	d they had client to relax			
	and B/P was reta	aken and they gave her			
	blood pressure n	nedications. I advised			
	_	client during the night for			
		ects. Call me in the			
	1 -	B/P before giving her			
		o documentation was			
		iew to indicate what			
	client A's B/P re				
		vas available for review			
		cal attention or a physical			
	_	licensed medical staff			
	was given to clie	ent A in regards to her			
	low BP reading.				
	-Nursing notation	on dated 1/3/13:			
	"Received a pho	ne call from group home			
	DSP stated her (client A)'s B/P was 85/82			
	Pulse 53. I advi	sed staff to not give her			
		and to bring her blood			
		tion Metoprolol 50 mg			
	_	ne workshop with her and			
		and S Tech. While at the			
	_	/P was left arm 69/33 and			
	_	I called forAmbulance			
	_				
	_	nt to the ER-[Name of			
	_	aluation and treatment.			
		ved at the [Day Program			
	name] to transpo	ort client to the ER."			
	-Nursing notation	on dated 1/3/13:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 03/15	LETED	
	PROVIDER OR SUPPLIER			STREET A 300 W 5	DDRESS, CITY, STATE, ZIP COD 3RD AVE N 46410	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	(Intensive Care U	admitted to the ICU Jnit) at [Name of sis of Hypotension, Renal Failure."					
	There was no do to indicate the fa						
	A] will be transfe Hospital Unit] for treatment on 1/10 record failed to it assessments were	n dated 1/15/13: "[Client erred to the [Name of or her chemotherapy 6/13." Review of the ndicate risk plans and/or e completed for client A chemotherapy treatments.					
	A] was discharge todayUpon rec assessment it wa has 3 areas of co decube [an open left buttock, a sn chest and a small her toes. Hospita ARC. [Client A] wound clinic on wounds. [Client	n dated 1/23/13: "[Client ed from the hospital eiving a post hospital s found that [client A] ncern on her body. A sore on her body] on her nall open area on her left I area of concern between I did not report to the will be seen at the 1/29/13 to address all A] also came home with ibrillator. A machine					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G040	B. WING		03/15/2013
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
APC OF	NORTHWEST IND	NANA INC. THE		53RD AVE IN 46410	
				T +0+10	(ME)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	was sent to the	house to be placed by her			
	bed which will	monitor her from midnight			
	until 6 A.M7	days a week. [Client A] is			
	still a bit weak	from being in the hospital			
	and will require	staff to assist her with			
	transports until	she is steady on her feet.			
	[Client A] will	remain home until after			
	she is seen at th	e wound clinic on			
	1/29/13Will f	follow up with doctor			
	regarding physi	cal therapyreceived			
	chemotherapy is	n hospital need to follow			
	up regarding tre	eatments[RN name] will			
	update risk plan	ns." There was no			
	documentation	in the record to indicate			
	the facility's nur	rsing services developed			
	and implemente	ed risk plans to give staff			
	_	ent A's skin breakdown,			
	her pacemaker,	chemotherapy and			
	mobility needs.				
	Carre have d	-:11 f1:4 A			
	_	aily logs for client A dnesday, 1/23/13: [Client			
		ne today from the she arrived at the group			
	_	0 1			
	•	staff to help her from the wheelchair. She has been			
		ath and couldn't seem to			
	1 ' '	breathThursday, 1/24/13:			
		staff heard [client A] yell k on her. She was on the			
		r bed, when staff asked			
		she stated that she tried to			
	get up to use the				
	get up to use the	C DatiffOlii			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G040	B. WIN			03/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t		300 W 5	53RD AVE		
	NORTHWEST IND	·			IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	S PLAN OF CORRECTION	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	_	n dated 1/28/13:					
		from staff on 1/27/13					
		as having difficulty					
		had called 911 and was					
		the ambulance to arrive.					
		dmitted to [Name of					
	Hospital] for lov	v 02 levels (Oxygen)."					
	-Nursing notatio	n dated 1/28/13: "While					
	doing a body che	eck it was found that					
	[client A] had a	deep cut on her foot that					
	had possibly occ	curred during ambulance					
	transport. Six st	itches were required to					
	close the wound	. Investigation initiated."					
	-Nursing notatio	n dated 2/8/13: "Heels					
	1	There is some maceration					
	under toes right	foot Bacitracin					
		g with dry gauze-foam					
		" There was no further					
	_	n client A's medical					
		notation from the					
		services regarding the					
	client's skin on h						
	Further review of	of client A's record failed					
		icility's nursing staff					
		nplemented medical risk					
	_	client A's health care					
	-	to skin break down,					
	_	on, breathing difficulties,					
		lefilibrator, her diagnosis					
	_	otherapy treatments,					
		and how staff were to					
	I hypercareenna, a	ma now starr were to					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLI	ETED
		15G040	B. WIN			03/15/	2013
NAME OF B			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C		300 W 5	53RD AVE		
	NORTHWEST IND	IANA INC, THE		GARY,	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	assist client A or	n her mobility needs.					
	who worked with home in regards health concerns 12:30 P.M No submitted for rev facility's nursing staff who worked group home with	ining records for all staff h client A at the group to her mobility needs and was made on 2/28/13 at training records were view to indicate the g services provided all d with client A at the h training to assist in es to address her health					
	all staff who work group home in re- needs and health 3/1/13 at 11:15 A were submitted to facility's nursing staff who worked group home with	t for training records for rked with client A at the egards to her mobility a concerns was made on A.M No training records for review to indicate the a services provided all d with client A at the a training to assist in es to address her health					
	12:15 P.M A remade. The admit answer any quest asked if client A had active TB, the	th the facility's as conducted on 3/1/12 at equest to interview was inistrator stated "I can tions you have." When had a history of TB or me administrator stated "I ill have to check." The					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 03/15		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	"I'm not sure." I interview.	t and returned and stated No nurse was available for						
	P.M. observation conducted at the walked throughor kitchen, living rollaundry room far At 5:12pm, client in her bedroom, to the washer, purclient B called for client B indicate pain. At 5:25pm to rate her pain "10 being the great responded an "1 pain was on her 5:42pm, GHS #2 (client B) in pair indicated no documented or rollient B indicate documented or rollient B's Madministration I did not indicate documented or rollient B's Ma	1." Client B indicated her right top shoulder. At 2 stated "I know she's a now." GHS #2 umentation "about [client vailable for review. At MAR (Medication Record) was reviewed and client B's pain was ecorded.						
	client B complai shoulder to Direc #1 and #2 and th	4:05pm until 6:15pm, ned of pain to her right et Support Professionals e surveyors. When DSP client B had medication						

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY SPLETED 15/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			
	to address her pain, DSP #2 indicated she did but she (DSP #2) would have to call the facility's administrator to make sure she could administer client B's pain medication. When asked if she were going to call the nurse, DSP #2 stated "We don't have contact with the nurse; we call [administrator's name] and she directs us on what to do." At 6:15 P.M., the facility's administrator called back and spoke to DSP #1. Client B did not get her pain medication. When asked if staff documented client B's pain, DSP #1 and DSP #2 indicated they did not because they contacted the Administrator. At 6:15pm, client B's 2/2013 MAR (Medication Administration Record) was reviewed and staff did not make entries to indicate client B had expressed pain. Client B's record was reviewed at the agency on 2/28/13 at 12noon. Client B's 2/15/13 Physician's Progress note indicated "R (Right) Shoulder pain" and ordered a CT (Cat Scan) of client B's right shoulder. Client B's 2/27/13 "Cumulative Medical Record" documentation sheet indicated "CT scan R shoulder done," no results were recorded, and it was signed by the contract LPN (Licensed Practical Nurse). Client B's 1/28/13 "Physician's Order" indicated "Acetaminophen 325mg (milligrams), give 2 tablets (650mg) every 4hrs (four hours) as needed (for)							

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PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		00	COMPLE 03/15/2	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	ddress, city, state, zip co 3RD AVE N 46410	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	headache/pain, Aspirin 325mg tablet (for pain), give 1 tablet orally 2 times a day as needed, Ibuprofen 800mg tablet, give 1 tablet orally every 6 hours as needed (for pain)." Client B's 9/24/2009 "Health Risk Plan" indicated "Osteoarthritis, client has potential pain related to Osteoarthritis. Client's pain will be at a tolerable level as evidenced by verbalization or signs of absence of painstaff will document on MAR pain level and medications and their effectiveness." On 3/1/13 at 11:45am, an interview with the SC (Service Coordinator) was completed. The SC indicated client B's pain should have been recorded on the MAR. The SC indicated client B was seen by the doctor on 2/15/13 because of pain and client B's right shoulder had a CT scan completed on 2/27/13. The SC indicated the results of client B's CT scan were not available for review. 9-3-6(a)				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040		LDING	ONSTRUCTION 00	(X3) DATE (COMPL 03/15 /	ETED
	ROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W000336	clients certified as care plan, a revie which must be on frequent basis de Based on record 2 of 3 sampled c facility's nursing conduct quarterly client B and C's needs. Findings include 1. Client B's record agency on 2/28/1 record indicated assessments on 1 4/12/12. No Nuravailable for reviculent B's 7/19/1 Plan (ISP) indicatincluded, but we Osteoarthritis kn Willi Syndrome, Anxiety. Client orders indicated medications. On 3/1/13 at 11:4 the SC (Service of the same plant is a review of the same plant is a re	must include, for those is not needing a medical wof their health status a quarterly or more pending on client need. review and interview for lients (B and C), the services failed to y nursing assessments of health status and medical in the services failed to y nursing Quarterly on the services failed to y nursing Quarterly on the services failed to y nursing Quarterly on the services failed to y nursing Quarterly was in the services failed to grant for the services failed to the services failed to y nursing Quarterly was in the services of the services failed to the services of the services failed to grant for the serv	W0	00336	The Community Service Nurse will complete a Quarterly Nurs Assessment for each client on quarterly basis 4/10/13. To ensure future compliance, The Service Coordinator will review Quarterly Nursing Assessment to ensure there is one complet per client per quarter. Nursing manager will be notified each time one is missed.	ing a e v all ts	04/14/2013

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	A. BUI	LDING	00	COMPL	
		15G040	B. WIN			03/15/	2013
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC. THE			53RD AVE IN 46410		
			1	<u> </u>	111 10110		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	healthcare needs	was available for review.					
		., 45 4, 41, 46, 16, 16, 16, 16, 16					
	2 Client C's rec	ord was reviewed 3/1/13					
		ent C's 7/23/12 ISP					
		oort Plan) did not indicate					
		edical care plan. Client					
		client C's diagnoses					
		re not limited to, Severe					
	-	ion, Dermatitis, and					
		nent. Client C's record					
	indicated she rec						
		ient C's record indicated					
	nursing quarterly						
		2/12. No additional					
		assessments were					
	available for rev						
	wywiiwoio ioi ioy						
	On 3/1/13 at 12:	15pm, an interview with					
		lucted. The SC indicated					
		have nursing quarterly					
	assessments sinc						
	9-3-6(a)						
							l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G040	B. WIN			03/15/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			300 W 5	53RD AVE		
	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000342	483.460(c)(5)(iii) NURSING SERV Nursing services with other member team, appropriate health measures limited to training detecting signs and dysfunction, first a and basic skills reneeds of the clien. Based on observer record review, for (clients A and B) services failed to in regard to docure readings on the Administration Fensure staff were documentation of and/or body/reports and services failed to interest facility states to provide care for the facility states of the facility's interports and Burer staff were of the facility's interports and Burer staff were for the facility's interports and Burer staff were facility states and services facility's interports and Burer staff were facility in the facility's interports and Burer staff were facility in the facility's interports and Burer staff were facility in the facility's interports and Burer staff were facility in the facility's interports and Burer staff were facility in the facility in the facility in the facility is interports and Burer staff were facility in the facility in the facility in the facility is interported and the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility in the facility in the facility is in the facility is in the facility in the	ICES must include implementing ers of the interdisciplinary er protective and preventive that include, but are not direct care staff in and symptoms of illness or eaid for accidents or illness, equired to meet the health ents. ation, interview, and or 2 of 3 sampled clients or ensure staff were trained ensure in the facility's nursing or ensure staff were trained ensured in regard to er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er skin breakdown. Example 1 is a simple of the client's daily notes er trained in regard to er trained in	W0	TAG 00342	The community services nurse will re-train all staff on how to properly document areas of concern such as Blood pressureading on the MAR, repositioning sheets, and care skin break down, bowel and bladder tracking, and any othe specific tracking forms needed 4/14/13. The IDT will review Audio logical, Nutritional, health, developmental and other assessments as they a received or at least annually compare them to Client goals and risk plans to ensure that areas of need are being addressed. The Behavior health director or designee we perform a random audit of client files at least quarterly the ensure that emerging client needs are being addressed by the team. To ensure future compliance, the Area manage will refer all new staff to the hot to the Community Services	re for r by re to s all rill o	DATE 04/14/2013
		nt/accident report dated .M.: "Received a call			Nurse, whom will ensure staff trained on all medical needs for the home documentation will be	or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G040	B. WIN	G		03/15/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					53RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	- 4 -	DATE
		e staff that the consumer's			forwarded to the area manage assure completion. Software		
	_	vas low. I informed staff					
		B/P (blood pressure)			being developed to track staff training to each location that t		
	medications unti				work to ensure all are		
	•	(sic) Health and Safety			appropriately trained. This	.,	
		her B/P. Blood pressure			software is expected to be full functional within 6 months. In	-	
		y the Health /Safety			interim, Area Mangers will		
		r blood pressure was low.			monitor training through pape	r file	
		called to transport her to			audits.		
	[Name of Hospit	tal] for evaluation and					
	treatment. What	measure(s) do you think					
	could prevent re-	occurrence of this					
	Incident/Accide	nt? Staff need (sic) to					
	follow instruction	ns and pay close attention					
	to what they are	doing. Give medication					
		hould be done. Part					
	B-Action Taken	Consumer was sent to					
	the ER (Emerge	ncy Room) @ [Name of					
		aluation and treatment."					
		cumentation available for					
	review to indicate	te the facility staff were					
		client A's blood pressure					
	readings.	reserved to the process of the proce					
	,						
	A review of clie	nt A's record was					
		facility's administrative					
		3 at 12:15 P.M Review					
		dical record indicated the					
	following:	incui record indicated the					
	ionowing.						
	-A review of clie	ent A's lab levels date of					
		/12 and results faxed to					
		0/26/12 indicated:					
	CreatineOut of	of Range 1.17Reference					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G040			LDING	NSTRUCTION 00	(X3) DATE COMPI 03/15			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	Range 0.60-0.93 patients >49 yea limit for Creating higher for people African-America Range 11.3Ref 8.6-10.4Parath Range 88Refer There was no do to indicate if the gave guidance of symptoms in reg levels. -Nursing notatio "Consumer will Hospital] for Hy calcium levels in Telemetry unit (name) ordersE [Doctor's name] does not have an bedsConsumer Doctor aware. C 11.3, Parathyroid -Nursing notatio "Consumer is ad Hospital] camput history of Hyper -Nursing notatio "Consumer was	mg (milligrams)For rs of age, the reference e is approximately 13% e identified as anCalciumOut of Gerence Range yroid HormoneOut of rence Range 10-65." cumentation in the record facility's nursing services r training to staff on ards to client A's high lab and the blood) on a monitoring) per [Doctor's R visit was canceled per orders due to hospital y available by a value of the staff of the company of the staff of the staff of the staff of the blood on a monitoring of the blood of						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G040	(X2) MULTIP A. BUILDING B. WING		TRUCTION 00	(X3) DATE : COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	to why consume on 11/8/12 after	Pneumonia was noted as r's surgery was canceled she was placed on the coxygen level dropped by a Pulmonary						
	_	n dated 11/23/12: "She BT's (Intravenous in TB isolation."						
	-Nursing notatio remains in TB is	n dated 11/26/12: "She colation."						
	summary dated taking these med mgTake 1 tabl Review of Isonia antibiotic used to bacteria from more of client A's recordient A had activate as to why she was and was discharge There was no do review to indicate trained for client	A's hospital discharge 12/21/12 indicated: "Start dications-Isoniazid 300 et by mouth daily." azid indicated it is an o keep tuberculosis altiplying. Further review ord did not indicate if ve TB or a history of TB as isolated on the TB unit ged on TB medication. becumentation available for te the facility staff were a A's symptoms regarding and medical care by a						
	"Lung biopsy	n dated 11/29/12: noted to show that she denocarcinoma (lung						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		15G040	B. WIN			03/15/2	2013
NAME OF B	DROWNER OF GUIDNI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			300 W 5	53RD AVE		
	NORTHWEST INDI				IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
	cancer)"						
	-Nursing notation dated 1/3/13:						
	-	ne call from group home					
	on 1/2/13 DSP (1	Direct Support					
	Professional) sta	ted that consumers B/P					
	had been low and	d they had client to relax					
	and B/P was reta	ken and they gave her					
	blood pressure n	nedications. I advised					
	staff to monitor	client during the night for					
		cts. Call me in the					
	-	B/P before giving her					
	_	documentation was					
		iew to indicate what					
	client A's B/P res						
		f training for client A's					
		was available for review.					
	Blood Plessure V	vas avanabie ioi review.					
	-Nursing notation						
	1	ne call from group home					
	DSP stated her (client A)'s B/P was 85/82					
	Pulse 53. I advis	sed staff to not give her					
	B/P medications	and to bring her blood					
	pressure medicat	tion Metoprolol 50 mg					
	(milligram) to th	e workshop with her and					
	give it to the H a	nd S Tech. While at the					
	workshop her B/	P was left arm 69/33 and					
	1	I called for Prompt					
	•	ansport client to the ER-					
		al] for evaluation and					
		ulance arrived at the [Day					
	Program name] to transport client to the						
	ER."	o numport enemt to the					
	EIX.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	A. BUI	LDING	00	COMPLETE 03/15/20	
		130040	B. WIN		PRESIDENCE CONTROL CON	03/13/20	10
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			IN 46410		
(X4) ID			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	re C	OMPLETION DATE
TAG	-Nursing notatio		_	TAU			DATE
	_	admitted to the ICU					
		Unit) at [Name of					
	`	sis of Hypotension,					
		Renal Failure." No					
		f training for client A's					
		available for review.					
	-Nursing notatio	n dated 1/11/13:					
"Consumer had the							
pacemaker/defibrillator placed today."							
	_	staff training for client					
		Defibrillator was available					
	for review.						
		n dated 1/15/13: "[Client					
	A] will be transf	erred to the [Hospital					
	_	motherapy treatment on					
		cumented staff training					
		dical care and monitoring					
		s of chemotherapy was					
	available for rev	iew.					
	-Nursing notatio	n dated 1/23/13: "[Client					
	_	ed from the hospital					
		eiving a post hospital					
		s found that [client A]					
	has 3 areas of co	ncern on her body. A					
	decube (an open	sore on her body) on her					
	left buttock, a sn	nall open area on her left					
	chest and a smal	l area of concern between					
	her toes. Hospita	al did not report to the					
	ARC. [Client A] will be seen at the					
	wound clinic on	1/29/13 to address all					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013	
	PROVIDER OR SUPPLIE		300 W	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	a pacemaker/def was sent to the hed which will runtil 6 A.M7 d still a bit weak f and will require transports until s [Client A] will reshe is seen at the 1/29/13Will for regarding physic chemo in hospit regarding treatm update risk plan. A review of grown client A indicate [Client A] was shospital. When home, it took 3 scar and into her gasping for breacheck (sic) her bundle and ran to check floor next to her what happened seget up to use the "Received a call that [client A] was short and ran to check floor next to her what happened seget up to use the "Received a call that [client A] was short and ran to check floor next to her what happened seget up to use the "Received a call that [client A] was short and ran to check floor next to her what happened seget up to use the "Received a call that [client A] was short and the s	up home daily logs for ed: "Wednesday, 1/23/13: eent home today from the she arrived at the group staff to help her from the wheelchair. She has been th and couldn't seem to creathThursday, 1/24/13: staff heard [client A] yell to on her. She was on the bed, when staff asked she stated that she tried to			

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PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		A. BUILDING B. WING			COMPLETED 03/15/2013		
		100040	B. WIN			00/10/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			53RD AVE IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	_	mbulance to arrive.					
		dmitted to [Name of					
	Hospital] for low	02 levels (Oxygen)."					
		nt A's record at the group					
		erview were conducted on					
	•	n, with the SC/QMRP					
		ator/Qualified Mental					
	Retardation Profe	essional) and Group					
	Home Staff (GH)	S) #2. The SC/QMRP					
	and GHS #2 both	n indicated one					
	unidentified grou	p home staff was trained					
	for client A's med	dical care by the Hospice					
	Nurse after client	t A returned to the					
	facility. Both sta	aff indicated the one					
	unidentified grou	ip home staff who was					
	trained, then train	ned another staff on					
	client A's medica	al care. GHS #2					
	indicated that gro	oup home staff then					
	_	up home staff. GHS #2					
		nsed nurse instructed the					
		p home staff on client A's					
	medical care. No	•					
		rding the staff training					
	was available for	_					
	45 4 7 4114 510 101						
	Further review of	f client A's record failed					
		cility's nursing staff					
		nplemented medical risk					
	-	client A's health care					
	-	to skin break down,					
	_	on, breathing difficulties,					
	her pacemaker/de	_					
	*	lient A's diagnosis of					
	Chemomerapy, ci	nent A's diagnosis of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G040	B. WIN	G		03/15/	2013
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIE	R		300 W 5	53RD AVE		
ARC OF	NORTHWEST IND	DIANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cancer, and how staff					
	were to assist c	lient A on her mobility					
	needs.						
	A request for tra	aining records for all staff					
	who worked wi	th client A at the group					
	home in regards	s to her mobility needs and					
	health concerns	was made on 2/28/13 at					
	12:30 P.M No	training records were					
	submitted for re	eview to indicate the					
	facility's nursin	g services provided all					
	_	ed with client A at the					
	group home wit	th training to assist in					
		ces to address her health					
	care needs.						
	care needs.						
	A second reque	st for training records for					
	^	orked with client A at the					
		regards to her mobility					
		h concerns was made on					
		A.M No training records					
		for review to indicate the					
	-	g services provided all					
		ed with client A at the					
	U 1	th training to assist in					
		ces to address her health					
	care needs.						
		:4 4 C :					
	An interview w						
	,	C) was conducted on					
		A.M When asked if					
		nentation to indicate					
		ff were trained to provide					
	care for client A	a's documented needs, the					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	E SURVEY PLETED 5/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	DDRESS, CITY, STATE, ZIP CO 53RD AVE IN 46410	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	SC stated "I'm not sure what the nurses trained the staff on." When asked if a nurse was available for interview, the SC stated "They are out of the building at lunch right now." When asked when nursing staff would be available for interview, the SC stated "You'll have to talk to [Administrator's name] about that." No documentation was submitted for review to indicate group home staff were trained to provide needed services for client A's documented health needs. An interview with the facility's administrator was conducted at the facility's administrative office on 3/1/13 at 12:15 P.M When asked if a nurse was available for interview, the administrator stated "No. I can answer any questions you have." When asked when group home staff were provided training to provided services to address client A's health needs, the administrator stated "I'm not sure." 2. On 2/27/13 from 4:05 P.M. until 6:15 P.M. observation and interviews were conducted at the group home. Client B walked throughout the group home, kitchen, living room, bedrooms, and laundry room favoring her right shoulder. At 5:12pm, client B gathered her laundry in her bedroom, carried the dirty laundry to the washer, put the laundry inside, and				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013	
	PROVIDER OR SUPPLIED		STREET A	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	client B indicate pain. At 5:25pn to rate her pain '10 being the gre responded an "1 pain was on her 5:42pm, GHS #2 (client B) in pain B's MAR (Medi Record) was revindicate client B or recorded. On 2/27/13 from client B complais shoulder to Dire #1 and #2 and th #2 was asked if to address her paid but she (DSI the facility's adminimedication. Whe going to call the "We don't have call [administrate us on what to do facility's adminimedication what to DSP #1 pain medication	1." Client B indicated her right top shoulder. At 2 stated "I know she's in now." At 6pm, client cation Administration riewed and did not it's pain was documented at 4:05pm until 6:15pm, fined of pain to her right ct Support Professionals he surveyors. When DSP client B had medication ain, DSP #2 indicated she in the pain was documented at the pain was documented by the pain was a state of the pain was a state			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G040	B. WIN	IG		03/15/	2013
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
					S3RD AVE		
ARC OF NORTHWEST INDIANA INC, THE				GARY,	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		<u> </u>	-	TAG	DEFICIENCI)		DATE
		l was reviewed at the					
	" "	13 at 12noon. Client B's					
		in's Progress note					
	, ,	ght) Shoulder pain" and					
		an of client B's right					
		B's 2/27/13 "Cumulative					
		documentation sheet					
		can R shoulder done" and					
		ntract LPN (Licensed					
	· · · · · · · · · · · · · · · · · · ·	Client B's 1/28/13					
	"Physician's Ord						
	_	325mg (milligrams),					
	•	50mg) every 4hrs (four					
	· · · · · · · · · · · · · · · · · · ·	I (for) headache/pain,					
		ablet (for pain), give 1					
		nes a day as needed,					
		g tablet, give 1 tablet					
		ours as needed (for pain)."					
		2009 "Health Risk Plan"					
		arthritis, client has					
		lated to Osteoarthritis.					
	•	l be at a tolerable level as					
	1	rbalization or signs of					
	•	staff will document on					
	_	and medications and					
	their effectivene	ss."					
		45am, an interview with					
	`	Coordinator) was					
	_	SC indicated client B's					
	pain should have	e been recorded. The SC					
	indicated no staf	f training documents					
	were available fo	or review in regards to					
	client B's pain m	anagement and client B's					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 15/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W	address, city, state, zi 53RD AVE IN 46410	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	9/2009 "Health Risk Plan." The SC indicated client B was seen by the doctor on 2/15/13 because of pain and client B's right shoulder had a CT scan completed on 2/27/13. 9-3-6(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040			LDING	ONSTRUCTION 00	(X3) DATE COMPL 03/15/	ETED	
	ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE
W000344	licensed nursing services on 2/19/1 An interview with agency darks on the agency darks on the agency agency payment indicated contract was not the agency administrator was services on 2/19/19/19/19/19/19/19/19/19/19/19/19/19/	employ or arrange for services sufficient to care needs including those all care plans. review and interview, the set of 5 clients residing at set A, B, C, D, and E), to ursing staff to care for eds from 2/13/13 until : facility's employee set was conducted on A.M. for the group home B, C, D, and E lived. cility's Registered Nurse record was reviewed. cord indicated the Newnton sick leave on pagency LPN staffing signed until 2/18/13 by the rand the contract Review of the contract invoice dated 2/23/13 at nursing staff began 113. the the facility's seconducted on 3/1/13 at seconducted on	W0	00344	Please See W 102		04/14/2013
		s conducted on 3/1/13 at administrator indicated					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	_			
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W 53RD AVE GARY, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	the facility's only RN is currently on sick leave but is on call and further indicated the facility went through a period (2/13/13 to 2/19/13) without any nursing staff.						
	9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/15/2013		
	ROVIDER OR SUPPLIER		p. ,,,,,,	STREET A	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000346	vocational nurses it must have a for registered nurse to onsite consultation or vocational nurses (clients A, B, C, failed to ensure a available to consulticensed practical staff met the heat clients. Findings include A review of the fractional record 2/28/13 at 11:55 facility's Register record was revier record indicated went on sick leave on documentation with to indicate the facility available to consulticensed practical records in the facility of the fa	es only licensed practical or to provide health services, mal arrangement with a to be available for verbal or in to the licensed practical se. Ew and record review, for iding at the group home D and E), the facility is registered nurse was ult and/or oversee I nurses to ensure nursing lith care needs of the Facility's employee is was conducted on A.M Review of the red Nurse (RN) personnel wed. Review of the the facility's only RN or 2/13/13 and was still 3/1/13. No further was submitted for review cility had an RN ult and/or oversee I nurses to ensure nursing lith care needs of the	W0	00346	Please See W 102		04/14/2013

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G040		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013	
	PROVIDER OR SUPPLIE		STREET A	ADDRESS, CITY, STATE, ZIP CODE 53RD AVE IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	12:15 P.M The the facility's onleave and further went through a nursing staff. The indicated there available, she is administrator by clients A, B, C, A request for control RN was made.	as conducted on 3/1/13 at e administrator indicated y RN is currently on sick or indicated the facility period without any he administrator further is no nurse physically only available to the phone contact to address y D and E's health needs. Ontact information for the The administrator stated my questions you have."			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DINC	00	COMPLETED
		15G040		A. BUILDING B. WING		03/15/2013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			53RD AVE	
ARC OF	NORTHWEST INDI	IANA INC, THE			IN 46410	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W000382	The facility must biologicals locked prepared for adm		1110	00202		0.4/1.4/2012
İ		ation, record review, and	WU	00382	The medications noted in W	04/14/2013
	· · · · · · · · · · · · · · · · · · ·	of 3 sampled clients			382 and all unlabeled medications were removed o	un
		cility failed to ensure the			3/31/13 The Community Service	
		ons were kept locked			Nurse will re-train all staff on the	
	when not being i	readied for			proper labeling and storage of	
	administration.				medications by 4/14/13. To	
	Findings include	:			ensure future compliance, the Community Services Nurse wi make unannounced visits to the home at least bi-weekly for thr	II ne
	An evening obse	ervation was conducted at			months and quarterly thereafte	· · · · · · · · · · · · · · · · · · ·
	1	on 2/27/13 from 4:05			ensure medications are stored	
		P.M., clients B, C, D, and			properly.	
		ndependently throughout				
		Client A lay in her bed				
		ked medications. At 5:03				
		stic lunch bag containing				
		f medication was in a				
	_	ting on client A's night				
		bed. The medications				
		A review of the bottles				
	indicated: "Vita	C				
		et (supplement)1 tablet				
	1 .	Isoniazid 300 mg tablet				
		vent tuberculosis bacteria				
		g)1 tablet orally once a				
	dayBrimonidir	ne Tartrate .15%				
	(glaucoma)Inst	till 1 drop into each eye				
	twice dailyHyd	drocodone 325 mg				
	1	orally every 6 hours as				
	needed."					

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	OF CORRECTION OF CORRECTION 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	00	- COM 03/1	TE SURVEY PLETED 5/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET A 300 W 5 GARY,	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	An interview with the Service Coordinator (SC) was conducted on 3/1/13 at 11:45 A.M The SC indicated all medications be kept locked in the medication cabinet. The SC indicated the facility followed the Living in the Community Core A/Core B medication administration training. No nurse was available for interview. On 3/1/13 at 11am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be kept secured. 9-3-6(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00			ETED
		15G040	A. BUII B. WIN			03/15/	2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
ADC OF I	NORTHWEST INDI	ANA INC. THE			53RD AVE IN 46410		
ANC OF				GART,	111 404 10		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000391	483.460(m)(2)(ii)	_					
	DRUG LABELING						
		remove from use drug					
	labels.	orn, illegible, or missing					
		ation, record review, and	l wo	00391	Please see W 382		04/14/2013
		cility failed for 1 of 3	***	00371	Flease see W 302		04/14/2013
	· · · · · · · · · · · · · · · · · · ·						
	•	(client A), to have wound					
	care medications	labeled.					
	Findings include	:					
	An evening obse	rvation was conducted at					
	the group home	on 2/27/13 from 4:05					
	P.M. until 6:30 F	P.M At 5:11 P.M., a					
		th several unlabeled					
	•	rved on client A's					
		and. Review of the					
	•						
		s indicated: "Repara					
		re-skin protectant with					
		ifungal Cream 2%					
	Miconazole Nitra	ate for the treatment of					
	jock itch, ring we	orm and athlete's foot."					
	There were also	3 clear plastic bottles					
	containing a clea	r liquid identified by					
	ū	rofessional (DSP) #2 as					
	• •	The bottles did not					
		s name or instructions for					
		The bottles did not					
	contain a label.						
		th DSP #2 was conducted					
	on 2/27/13 at 5:2	24 P.M DSP #2					
	indicated the unl	abeled medications were					
	used to treat clien	nt A's skin breakdown.					

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Event ID: PDMX11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G040	(X2) MULTIPLE CC A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	ADDRESS, CITY, STATE, ZIP (53RD AVE IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	DSP #2 further indicated the bottles did not have labels.				
	An interview with the Service Coordinator (SC) was conducted on 3/1/13 at 11:45 A.M The SC indicated all medications should have a pharmacy label on them. No Nurse was available for interview. 9-3-6(a)				

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Event ID: PDMX11

Facility ID: 000597

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED	
		15G040	B. WING			03/15/	2013	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					53RD AVE			
ARC OF	NORTHWEST INDI	ANA INC. THE			IN 46410			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
W000436		LSC IDENTIFFING INFORMATION)	-	TAG	Berielekery		DATE	
VVUUU436	483.470(g)(2) SPACE AND EQ	IIIDMENT						
		furnish, maintain in good						
		clients to use and to make						
	•	about the use of dentures,						
	eyeglasses, hear	ing and other						
		aids, braces, and other						
		by the interdisciplinary						
	team as needed l	-	1,,,,	00.42.6			0.4/1.4/2.01.2	
		review and interview, for	WO	00436	Please see 227 in addition a		04/14/2013	
	`	ients A, B, and C) who			desensitization plan will be for Client B will be reworked to			
	used adaptive de	vices, the facility failed			provide her with more prompti	na		
	to provide client	A's recommended lower			to wear her glasses. This	19		
	dentures, client I	3's recommended eye			prompting will be documented			
	glasses, and clien	nt C's recommended			Additionally, the plan will include			
	hearing aids.				alternative methods of carrying	•		
	<i>y</i>				her glasses between locations			
	Findings include				Staff will be trained on this new plan by 4/14/13. The tracking	V		
	1 mamgs merade	•			sheets for these consumers w	ill		
	1	lient A's record was			be monitored by the service			
					coordinator weekly for a month	ı		
		28/13 at 12:15 P.M			and then monthly thereafter.	Γhe		
		A's most current dental			IDT will review Nutritional,			
		d 4/30/12 indicated she			health, developmental and			
	wore upper and	lower dentures. Further			other assessments as they a			
	review of the rec	ord indicated: "Nursing			received or at least annually			
	notation dated 4/	30/12-Patient says her			compare them to Client goals and risk plans to ensure that			
	lower denture wa	as lost. In order to get			areas of need are being	ali		
		ed for a new denture we			addressed. The Behavior			
	* *	cumstances resulting in			health director or designee w	/ill		
	the loss." There	_			perform a random audit of			
		n client A's record			client files at least quarterly t	:0		
					ensure that emerging client			
	_	oss and/or replacement of			needs are being addressed b	У		
	client A's lower	dentures.			the team.			
	An interview wit	th the Service						
	Coordinator (SC) was conducted on						

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Event ID: PDMX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G040	B. WIN	G		03/15/2013	
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
450.05	NORTH WATERT IND				S3RD AVE		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFECENCE)		DATE
		A.M When asked if					
		es had been replaced, the					
		e no idea, I knew nothing					
		C further indicated she					
		en the dentures would be					
	replaced.						
	0 0 0/07/10 0	4.05					
		rom 4:05pm until 6:15pm,					
		erved at the group home					
		ne Staff (GHS) #1, #2,					
		t B did not wear her					
	^	lasses. No teaching or					
		her prescribed eye glasses					
	was observed.						
	Client Die neeen	1 4					
		l was reviewed on					
		on. Client B's 7/19/12 ISP					
		oort Plan) indicated a					
	-	wear her prescribed eye					
	1 -	3's 7/3/12 and 4/12/12					
	• •	rly" assessments					
		B wore prescribed eye					
	~	B's 11/4/11 visual					
		eated she wore prescribed					
	eye glasses.						
	On 3/1/13 at 11.	10am, an interview with					
		rdinator (SC) was					
		SC indicated client B					
	_	eye glasses and facility e prompted client B to					
		e prompted chefit B to					
	wear them.						
	3. On 2/27/13 fr	rom 4:05pm until 6:15pm,					
	l	1	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G040	B. WING		03/15/2013
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				53RD AVE	
ARC OF	NORTHWEST IND	IANA INC, THE	GARY,	IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		erved at the group home			
	_	ne Staff (GHS) #1, #2,			
		t C did not wear			
	_	ng aids. Client C sat in			
		, sat in the living room,			
		ughout the group home			
		rithout activity. Each time			
	· ·	2, and GHS #3 wanted to			
		he staff members walked			
		ook client C by the hand			
		staff wanted client C to sit			
		smiled at the speaker			
	each time, and d	id not communicate with			
	staff.				
	Client C's record	l was reviewed 3/1/13 at			
	11:20am. Clien	t C's 7/23/12 ISP			
	` .	oort Plan) did not indicate			
	a communication	n objective. Client C's			
	7/23/12 ISP indi	cated "Hearing			
	Difficulties. Au	diologist 6/23/06 (2006)			
	audio notes-Has	tried many forms of			
	amplification, is	unable to consistently			
	wear amplificati	on, all forms tried with			
	no success, unab	ole to wear amplification,			
	still able to com	municate with one to one			
	conversation wit	thout amplification, is			
	able to commun	icate with staff and			
	workshop, is giv	en verbal cues, and			
		, IDT (Interdisciplinary			
	Team) 2/11/09 (2009) discussed agreed			
		aware and communicate			
	` '	ther decline." Client B's			
	1	rom the hearing clinic			

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	OF CORRECTION IDENTIFICATION NUMBER: 15G040	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/15/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	300 W 5	ADDRESS, CITY, STATE, ZIP CODI 53RD AVE IN 46410	Е
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION
	indicated client C "was seen on 8/4/2011 for audiometric testing. Results of that evaluation(The) report indicated [client C] had utilized hearing aids in both ears in the past. Her most recent set of hearing aids was acquired from the clinic in 2006" Client C's 8/4/11 auditory evaluation indicated "suspect mild sloping to severe SNHL (hearing) in at least 1 (one) earRecommendation:discussed hearing aid candidacy with Service Coordinator." Client C's 1/24/13 "Physician's Order" indicated "hearing aid, on in the morning, check placement at 5pm, remove & store in an unlocked area at HS (night). Change Hearing Aid Battery every week on Sunday." On 3/1/13 at 12:15pm, an interview with the SC was conducted. The SC indicated client C did not wear hearing aids and did not have hearing aids available to wear. The SC indicated she was unaware of the 8/2011 recommendation made by the audiologist and was unaware of client C's physician's order to wear hearing aids. This federal tag relates to complaint #IN00123154.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00			COMPLETED	
		15G040	A. BUILDING B. WING			03/15/2013	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
450.05		ANA INO THE			53RD AVE		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W009999						•	
	State Findings:		W0	09999	The Behavior Health Director v	will	04/14/2013
					review BDDS reporting		
	460 IAC 0 2 1/L) The fellowing			requirements with the Service		
	460 IAC 9-3-1(b				Coordinator and DSPs that are	e	
	-	idential Facilities for			involved with 53rd Ave by		
	Persons with Dev	velopmental Disabilities			4/14/13. In order to identify of	her	
	rule was not met	<u>.</u>			areas of concern all other		
					Coordinators will be trained on	l	
	The residential n	rovider shall report the			reporting and investigation		
	-	-			requirements.In order to preve		
	-	nstances to the division			reoccurrences posters explain	ing	
		later than the first			client rights and reporting requirement will be made and		
	business day foll	owed by written			distributed to all group homes	and	
	summaries as rec	quested by the division.			the day program so that staff a		
					clients become more aware of		
	This state rule is	not met as evidence by:			requirements on an ongoing		
	Timo state rate is	not met as evidence by.			basis. Additionally all staff will	be	
	D 1 1	. 1			trained on reporting and		
		review and interview, the			investigation requirements for		
	•	4 of 4 reportable			Abuse Neglect, and Exploitation		
	incidents for 1 of	f 3 sampled clients (client			at least annually unless chang		
	A), to report to tl	he Bureau of			occur or need requires this to I		
	Developmental I	Disabilities Services			done more frequently. To ensu	re	
	(BDDS) in a time				that Service Coordinators are		
	(DDDS) in a time	ery manner.			trained on reporting and investigation requirements for		
					Abuse Neglect, and Exploitation	nn	
	Findings include	:			the Behavioral Health Director		
					review their training records at		
	A review of the f	facility's records was			least annually and document		
	conducted at the	facility's administrative			review of findings. Area		
		3 at 2:15 P.M Review			Managers will review DSP		
		nternal Incident/Accident			training records to ensure they	,	
					have been training at least		
	•	au of Developmental			annually and document review	of	
		es (BDDS) reports			findings. All new Service		
	indicated the foll	owing for client A:			Coordinators and DSPs will be	;	
					trained on reporting and		
					investigation requirements for		

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PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G040	A. BUII	DING	00	COMPL 03/15/	ETED
		100040	B. WIN	_		00/10/	2010
NAME OF P	PROVIDER OR SUPPLIER						
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46410		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR -Internal incident 1/3/13 at 6:30 A. from group home blood pressure w to with hold her l medications until workshop. I ask Tech to recheck l was rechecked by Tech. Consumer Ambulance was of [Name of Hospital treatment. What could prevent rec Incident/Accident follow instruction to what they are of in he way they sh B-Action Taken: the ER (Emergent Hospital] for eva	ANA INC, THE TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) L'Accident report dated M.: "Received a call e staff that the consumer's as low. I informed staff B/P (blood pressure)		STREET A	ADDRESS, CITY, STATE, ZIP CODE S3RD AVE IN 46410 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Abuse Neglect, and Exploitatic prior to working a home or with client. In addition, the Service Coordinators will be present in their homes at least two times month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well a the visit. The Behavioral healt Director will review progress notes regularly.	on n a per	(X5) COMPLETION DATE
	-Internal incident 1/3/13 at 9:40 A. received a call from ambulance will b A) to the hospital go to hospital."	report was submitted nt. t/accident report dated M.: "Health Safety tech om the Nurse stating an recoming to take (client l. Got [client A] ready to Further review of the ndicate a BDDS report					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI	
AND PLAN	OF CORRECTION	15G040	A. BUI	LDING	00	COMPL 03/15/	
		100040	B. WIN			03/15/	2013
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			53RD AVE IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	ated 1/27/13Date of					
	_	7/13Submitted Date:					
		d: "During hospital					
		spital #2 name], [client					
	-	. Plan to Resolve:					
	_	red at least 6 stitches on					
	her left toe. [Cli	ent A] is currently in the					
	hospital. While	visiting the hospital for					
	follow up on [cli	ent A]'s wound care,					
	[Hospital #2]'s N	Jursing staff indicated					
	that [client A] su	stained an injury during					
	transportation to	the hospital. Sometime					
	after [client A] le	eft the group home and					
	before she arrive	d at the hospital [client					
	A] hit her second	toe on her left foot in					
	transport. There	is no report from the					
	paramedic as to	specifically what she hit					
	her toe on but it	is suspected that the					
	transport gurney	bed rails were involved					
	per hospital staff	The paramedics					
	immediately repo	orted the injury to the					
	hospital staff and	d at least stitches were					
	needed to close t	he wound. No staff were					
	suspended and n	o internal investigation					
	can be completed	d as she was not in The					
	Arc NWI (North	west Indiana) care at the					
	time of the injury	y. It was previously					
	reported the [clie	ent A] was being					
	_	hortness of breath, this					
	•	focus of medical staff,					
		ocumentation of this					
	injury is not avai	lable for review but no					
		ed based on the reporting					
	_	and the care she					
							l

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13
13
(X5)
OMPLETION DATE
DATE

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		15G040	A. BUII	LDING	00	03/15/	
		130040	B. WIN			03/13/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE			300 W 53RD AVE GARY, IN 46410				
				<u> </u>	114 404 10		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710	REGUERTORTOR	ESC ISENTI TING IN GRAMMITON,		1710			BITTE
	-Nursing notation	n dated 1/2/12:					
		admitted to the ICU					
	(Intensive Care U						
		· -					
	•	ootension and Acute					
		No documentation was					
		view to indicate a BDDS					
	report was subm	itted of this incident.					
	Nimmin	4.4.4 1/02/12: UFCI:::::4					
	_	n dated 1/23/13: "[Client					
		ed from the hospital					
		eiving a post hospital					
		s found that [client A]					
		ncern on her body. A					
		area on her skin) on her					
		nall open area on her left					
	chest and a small	l area of concern between					
	her toes. [Client	A] wilt be seen at the					
	wound clinic on	1/29/13 to address all					
	wounds. [Client	A] also came home with					
	a pacemaker/def	ibrillator. A machine					
	was sent to the h	ouse to be placed by her					
	bed which will n	nonitor her from midnight					
		ays a week. [Client A] is					
		om being in the hospital					
		staff to assist her with					
	_	he is steady on her feet.					
	-	emain home until after					
	she is seen at the						
		DDS report was available					
	for review.	DD Teport was available					
	101 ICVIEW.						
	A review of the	Bureau of Developmental					
		ices (BDDS) reporting					
	Disabilities Selv	ters (ppps) reporting					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	15G040		LDING	00	03/15/	
		100040	B. WIN		DDDDGG GYRY GRAND GYR GODD	00/10/	2010
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE			300 W 53RD AVE GARY, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		PRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 1	March 1, 2011 was					
		28/13 at 7:00 P.M The					
	policy indicated: "It is the policy of the						
	-	ty Improvement Services					
		an incident reporting					
	and management system as an integral						
		the health and welfare of					
		eceiving services					
	1	BDDSIncidents to be					
	-	S include any event or					
		acterized by risk or					
	_	ting in of having the					
	-	t in significant harm or					
	injury to an indi	vidual including but not					
	limited to:						
	-"An emergency	intervention for the					
	individual result	ing from:					
	a. a physica	l symptom					
	b. a medica	l or psychiatric condition					
	c. any other	event"					
	-"An injury to ar	n individual when the					
	cause is unknow	n and the injury could be					
	indicative of abu	ise, neglect or					
	exploitation."						
	-"An injury to ar	n individual when the					
	cause of the inju	ry is unknown and the					
	injury requires n	nedical evaluation or					
	treatment."						
	-"A significant in	njury to an individual that					
	includes but is n	ot limited toe.					
	Lacerations which	ch require more than					
	basic first aid. f.	any occurrence of skin					
	breakdown related to decubitus ulcer,						
	regardless of sev	erityInitial incident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		15G040	B. WING		03/15/2013
NAME OF P	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP CODE	
ABC OF	NIODTH/MEST IND	IANIA INIC. THE		53RD AVE	
	NORTHWEST IND		ID GARY,	IN 46410	
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		·	TAG	Dia relative 1 y	DATE
		IS. Within 24 hours of			
	1	of a reportable incident,			
		rson shall file an incident			
	_	h BQIS using the DDRS			
	approved electro	onic iormat"			
	A i 4 i	th the Commiss			
	An interview wi				
	`	() was conducted at the			
	1	strative office on 3/1/13 at			
		e SC indicated these			
		ot reported to BDDS. No			
	further documentation was submitted for				
		te BDDS reports were			
	submitted for the	e mentioned incidents.			
	0.2.14.				
	9-3-1(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PDMX11

Facility ID: 000597

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